



**BlueCross BlueShield
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BARIATRIC SURGERY FOR MORBID OBESITY

Corporate Medical Policy

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Document Precedence

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Medical Policy

Description

Surgery for morbid obesity, termed bariatric surgery, falls into two general categories: 1) gastric-restrictive procedures that create a small gastric pouch, resulting in weight loss by producing early satiety and thus decreasing dietary intake; and 2) malabsorptive procedures, which produce weight loss due to malabsorption by altering the normal transit of ingested food through the gastrointestinal tract. Some bariatric procedures may include both a restrictive and a malabsorptive component.

Bariatric surgery is performed for the treatment of morbid (clinically severe) obesity. Morbid obesity is defined as a body mass index (BMI) greater than 40 kg/m² or a BMI greater than 35 kg/m² with associated complications including, but not limited to, diabetes, hypertension, or obstructive sleep apnea. Morbid obesity results in a very high risk for weight-related complications, such as diabetes, hypertension, obstructive sleep apnea, and various types of cancers (for men: colon, rectum, and prostate; for women: breast, uterus, and ovaries), and a shortened life span. A morbidly obese man at age 20 can expect to live 13 years less than his counterpart with a normal BMI, which equates to a 22% reduction in life expectancy.

The first treatment of morbid obesity is dietary and lifestyle changes. Although this strategy may be effective in some patients, only a few morbidly obese individuals can reduce and control weight through diet and exercise. The majority of patients find it difficult to comply with these lifestyle modifications on a long-term basis.

When conservative measures fail, some patients may consider surgical approaches. A 1991 National Institutes of Health (NIH) Consensus Conference defined surgical candidates as those patients with a BMI* of greater than 40 kg/m², or greater than 35

kg/m² in conjunction with severe co-morbidities such as cardiopulmonary complications or severe diabetes.

Resolution (cure) or improvement of type 2 diabetes mellitus after bariatric surgery and observations that glycemic control may improve immediately after surgery, before a significant amount of weight is lost, have promoted interest in a surgical approach to treatment of type 2 diabetes. The various surgical procedures have different effects, and gastrointestinal rearrangement seems to confer additional anti-diabetic benefits independent of weight loss and caloric restriction. The precise mechanisms are not clear, and multiple mechanisms may be involved.

Gastrointestinal peptides, glucagon-like peptide-1 (GLP-1), glucose -dependent insulintropic peptide (GIP), and peptide YY (PYY) are secreted in response to contact with unabsorbed nutrients and by vagally mediated parasympathetic neural mechanisms. GLP-1 is secreted by the L cells of the distal ileum in response to ingested nutrients and acts on pancreatic islets to augment glucose-dependent insulin secretion. It also slows gastric emptying, which delays digestion, blunts postprandial glycemia, and acts on the central nervous system to induce satiety and decrease food intake. Other effects may improve insulin sensitivity. GIP acts on pancreatic beta cells to increase insulin secretion through the same mechanisms as GLP-1, although it is less potent. PYY is also secreted by the L cells of the distal intestine and increases satiety and delays gastric emptying.

The following summarizes the different restrictive and malabsorptive procedures.

Gastric Restrictive Procedures

1. Vertical-Banded Gastroplasty (CPT code 43842)

Vertical-banded gastroplasty was formerly one of the most common gastric restrictive procedures performed in this country but has more recently declined in popularity. In this procedure, the stomach is segmented along its vertical axis. To create a durable reinforced and rate-limiting stoma at the distal end of the pouch, a plug of stomach is removed, and a propylene collar is placed through this hole and then stapled to itself. Because the normal flow of food is preserved, metabolic complications are uncommon. Complications include esophageal reflux, dilation, or obstruction of the stoma, with the latter 2 requiring reoperation. Dilation of the stoma is a common reason for weight regain. Vertical-banded gastroplasty may be performed using an open or laparoscopic approach.

2. Adjustable Gastric Banding (CPT code 43770—laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device [e.g., gastric band and subcutaneous port components])

Adjustable gastric banding involves placing a gastric band around the exterior of the stomach. The band is attached to a reservoir that is implanted subcutaneously in the rectus sheath. Injecting the reservoir with saline will alter the diameter of the gastric band; therefore, the rate-limiting stoma in the stomach can be progressively narrowed to induce greater weight loss, or expanded if complications develop. Because the stomach is not entered, the surgery and any revisions, if necessary, are relatively simple. Complications include slippage of the external band or band erosion through the gastric wall. Adjustable gastric banding has been widely used in

Europe; currently, 1 such device is approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States, Lap-Band (BioEnterics, Carpinteria, CA). The labeled indications for this device are as follows:

"The Lap-Band system is indicated for use in weight reduction for severely obese patients with a body mass index (BMI) of at least 40 or a BMI of at least 35 with one or more severe co-morbid conditions, or those who are 100 lbs or more over their estimated ideal weight according to the 1983 Metropolitan Life Insurance Tables (use the midpoint for medium frame). It is indicated for use only in severely obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise and behavior modification programs. Patients who elect to have this surgery must make the commitment to accept significant changes in their eating habits for the rest of their lives."

A second adjustable gastric banding device was approved by the FDA through the PMA process in September 2007, the REALIZE model (Ethicon Endo-Surgery, Cincinnati, OH). Labeled indications for this device are as listed below:

"The [REALIZE] device is indicated for weight reduction for morbidly obese patients and is indicated for individuals with a BMI of at least 40 kg/m², or a BMI of at least 35 kg/m² with one or more co-morbid conditions. The band is indicated for use only in morbidly obese adult patients who have failed more conservative weight-reduction alternatives, such as supervised diet, exercise, and behavior modification programs."

3. Open Gastric Bypass (CPT code 43846—gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb [150 cm or less] Roux-en-Y gastroenterostomy)

The original gastric bypass surgeries were based on the observation that post-gastrectomy patients tended to lose weight. The current procedure involves both a restrictive and a malabsorptive component, with horizontal or vertical partition of the stomach performed in association with a Roux-en-Y procedure (i.e., a gastrojejunostomy). Thus, the flow of food bypasses the duodenum and proximal small bowel. The procedure may also be associated with an unpleasant "dumping syndrome," in which a large osmotic load delivered directly to the jejunum from the stomach produces abdominal pain and/or vomiting. The dumping syndrome may further reduce intake, particularly in "sweets eaters." Operative complications include leakage and marginal ulceration at the anastomotic site. Because the normal flow of food is disrupted, there are more metabolic complications compared to other gastric restrictive procedures, including iron deficiency anemia, vitamin B-12 deficiency, and hypocalcemia, all of which can be corrected by oral supplementation. Another concern is the ability to evaluate the "blind" bypassed portion of the stomach. Gastric bypass may be performed with either an open or laparoscopic technique.

Note: In 2005, the CPT code 43846 was revised to indicate that the short limb must be 150 cm or less, compared to the previous 100 cm. This change reflects the common practice in which the alimentary (i.e., jejunal limb) of a gastric bypass has been lengthened to 150 cm. This length also serves to distinguish a standard gastric bypass with a very long or very, very long gastric bypass, as discussed further here.

4. Laparoscopic Gastric Bypass (CPT code 43644—laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy [roux limb 150 cm or less])

CPT code 43644 was introduced in 2005 and essentially described the same procedure as No. 3, but performed laparoscopically.

5. Mini-Gastric Bypass (no specific CPT code)

Recently, a variant of the gastric bypass, called the mini-gastric bypass, has been popularized. Using a laparoscopic approach, the stomach is segmented, similar to a traditional gastric bypass, but instead of creating a Roux-en-Y anastomosis, the jejunum is anastomosed directly to the stomach, similar to a Billroth II procedure. This unique aspect of this procedure is not based on its laparoscopic approach but rather the type of anastomosis used. It should also be noted that CPT code 43846 does not accurately describe the mini-gastric bypass, since CPT code explicitly describes a Roux-en-Y gastroenterostomy, which is not used in the mini-gastric bypass.

6. Sleeve gastrectomy (CPT code 43775- laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy [i.e., sleeve gastrectomy])

A sleeve gastrectomy is an alternative approach to gastrectomy that can be performed on its own, or in combination with malabsorptive procedures (most commonly biliopancreatic diversion with duodenal switch). In this procedure, the greater curvature of the stomach is resected from the angle of His to the distal antrum, resulting in a stomach remnant shaped like a tube or sleeve. The pyloric sphincter is preserved, resulting in a more physiologic transit of food from the stomach to the duodenum, and avoiding the dumping syndrome (overly rapid transport of food through stomach into intestines) that is seen with distal gastrectomy. This procedure can be done by the open or laparoscopic technique. Some surgeons have proposed this as the first in a 2-stage procedure for very high-risk patients. Weight loss following sleeve gastrectomy may improve a patient's overall medical status, and thus reduce the risk of a subsequent more extensive malabsorptive procedure, such as biliopancreatic diversion.

Endoluminal (also called endosurgical, endoscopic, or natural orifice) bariatric procedures

With these procedures access to the relevant anatomical structures is gained through the mouth without skin incisions. Primary and revision bariatric procedures are being developed to reduce the risks associated with open and laparoscopic interventions. Examples of endoluminal bariatric procedures studies include gastroplasty using a transoral endoscopically guided stapler and placement of devices such as a duodenal-jejunal sleeve and gastric balloon.

Malabsorptive Procedures

The multiple variants of malabsorptive procedures differ in the lengths of the alimentary limb, the biliopancreatic limb, and the common limb, in which the alimentary and biliopancreatic limbs are anastomosed. These procedures also may include an element of a restrictive surgery based on the size of the stomach pouch. The degree of malabsorption is related to the length of the alimentary and common limbs. For example, a shorter alimentary limb (i.e., the greater the amount of intestine that is excluded from the nutrient flow) will be associated with malabsorption of a variety of nutrients, while a short common limb (i.e., the biliopancreatic juices are allowed to mix with nutrients for only a short segment) will primarily limit absorption of fat.

1. Biliopancreatic Bypass Procedure (also known as the Scopinaro procedure) (CPT code 43847— gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption)

Biliopancreatic bypass (BPB) procedure, developed and used extensively in Italy, was designed to address some of the drawbacks of the original intestinal bypass procedures that have been abandoned due to unacceptable metabolic complications. Many of the complications were thought to be related to bacterial overgrowth and toxin production in the blind, bypassed segment. In contrast, BPB consists of a subtotal gastrectomy and diversion of the biliopancreatic juices into the distal ileum by a long Roux-en-Y procedure. The procedure consists of the following components.

1. A distal gastrectomy induces a temporary early satiety and/or the dumping syndrome in the early postoperative period, both of which limit food intake.
2. A 200-cm long “alimentary tract” consists of 200 cm of ileum connecting the stomach to a common distal segment.
3. A 300- to 400-cm “biliary tract” connects the duodenum, jejunum, and remaining ileum to the common distal segment.
4. A 50- to 100-cm “common tract,” is where food from the alimentary tract mixes with biliopancreatic juices from the biliary tract. Food digestion and absorption, particularly of fats and starches, are therefore limited to this small segment of bowel, i.e., creating a selective malabsorption. The length of the common segment will influence the degree of malabsorption.
5. Because of the high incidence of cholelithiasis associated with the procedure, patients typically undergo an associated cholecystectomy.

Many potential metabolic complications are related to biliopancreatic bypass, including most prominently iron deficiency anemia, protein malnutrition, hypocalcemia, and bone demineralization. Protein malnutrition may require treatment with total parenteral nutrition. In addition, there have been several case reports of liver failure resulting in death or liver transplant.

2. Biliopancreatic Bypass with Duodenal Switch (CPT code 43845—gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy [50 to 100 cm common channel] to limit absorption [biliopancreatic diversion with duodenal switch])

CPT code 43845, which specifically identifies the duodenal switch procedure, was introduced in 2005. The duodenal switch procedure is essentially a variant of the biliopancreatic bypass described here. In this procedure, instead of performing a distal gastrectomy, a sleeve gastrectomy is performed along the vertical axis of the stomach. This approach preserves the pylorus and initial segment of the duodenum, which is then anastomosed to a segment of the ileum, similar to the biliopancreatic bypass, to create the alimentary limb. Preservation of the pyloric sphincter is intended to ameliorate the dumping syndrome and decrease the incidence of ulcers at the duodenoileal anastomosis by providing a more physiologic transfer of stomach contents to the duodenum. The sleeve gastrectomy also decreases the volume of the stomach and decreases the parietal cell mass. However, the basic principle of the procedure is similar to that of the biliopancreatic bypass, i.e., producing selective malabsorption by limiting the food digestion and absorption to a short common ileal segment.

3. Long-Limb Gastric Bypass (i.e., >150 cm) (CPT code 43847—Gastric restrictive procedure with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption)

Recently, variations of gastric bypass procedures have been described, consisting primarily of long-limb Roux-en-Y procedures, which vary in the length of the alimentary and common limbs. For example, the stomach may be divided with a long segment of the jejunum (instead of ileum) anastomosed to the proximal gastric stump, creating the alimentary limb. The remaining pancreaticobiliary limb, consisting of stomach remnant, duodenum, and length of proximal jejunum is then anastomosed to the ileum, creating a common limb of variable length in which the ingested food mixes with the pancreaticobiliary juices. While the long alimentary limb permits absorption of most nutrients, the short common limb primarily limits absorption of fats. The stomach may be bypassed in a variety of ways, i.e., either by resection or stapling along the horizontal or vertical axis. Unlike the traditional gastric bypass, which is essentially a gastric restrictive procedure, these very long-limb Roux-en-Y gastric bypasses combine gastric restriction with some element of malabsorptive procedure, depending on the location of the anastomoses. Note that CPT code for gastric bypass (43846) explicitly describes a short limb (<150 cm) Roux-en-Y gastroenterostomy, and thus would not apply to long-limb gastric bypass.

4. Laparoscopic Malabsorptive procedure (CPT code 43645—Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption)

CPT code 43645 was introduced in 2005 to specifically describe a laparoscopic malabsorptive procedure. However, the code does not specifically describe any specific malabsorptive procedure.

Policy

General Criteria for Patient Selection and Coverage:

- Morbid obesity is defined as a body mass index (BMI) greater than 40 kg/m² or a BMI greater than 35 kg/m² with at least one clinically significant obesity-related disease such as diabetes mellitus, obstructive sleep apnea, coronary artery disease, or hypertension for which these complications or diseases are not controlled by best practice medical management.
- To determine whether or not patients have responded to conservative measures for weight reduction, patients must have been active participants in non-surgical weight reduction programs that include frequent, e.g., monthly, documentation of weight, dietary regimen, and exercise. In general, patients must have participated in these programs for at least 6 months. These conservative attempts must be reviewed by the practitioner seeking approval for the surgical procedure.
- Patients with BMI greater than or equal to 50 kg/m² need a bariatric procedure to achieve greater weight loss. Thus, use of adjustable gastric banding, which results in less weight loss, should be most useful as one of the procedures used for patients with BMI less than 50 kg/m². Malabsorptive procedures, although they produce more dramatic weight loss, they potentially result in nutritional complications, and the risks and benefits of these procedures must be carefully weighed in light of the treatment goals for each patient.

To calculate BMI, follow these instructions:

- To convert pounds to kilograms, multiply pounds by 0.45
 - To convert inches to meters, multiply inches by 0.0254
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- The patient must be at least 18 years of age (The U.S. Food and Drug Administration (FDA) premarket approval for the LAP-BAND System indicates it is for use only in severely obese adult patients. The clinical study that was submitted to the FDA for approval of the LAP-BAND was restricted to adults aged 18-55 years.)
 - The patient has participated in at least one medically supervised attempt to lose weight within the 2 years preceding surgery. The medically supervised weight loss attempt(s) must include at least six(6) monthly medical visits over six (6) consecutive months with all visits under the direction of a medical doctor (MD or DO), physicians' assistant (PA), nurse practitioner (NP) or a registered dietitian supervised by an MD, DO, PA, or NP. The patient's participation in a structured weight loss regimen must be documented in the medical record by an attending practitioner who supervised the patient's progress. A physician's notation alone is not sufficient documentation. Documentation should include medical records indicating the patient's adherence to the current nutrition and exercise program throughout the course of the medically supervised weight loss regimen. Such documentation is

necessary to establish the patient's ability to comply with the dietary and lifestyle changes necessary for maintaining weight loss following surgery.

- The patient must be evaluated preoperative by a licensed mental health provider (i.e. psychiatrist, licensed psychologist [PhD or MA] or licensed clinical social worker [LCSW]) to ensure the patient's ability to understand, tolerate and comply with all phases of care and to ensure a commitment to long term follow-up requirements. The evaluation must document that any psychiatric, chemical dependency, or eating disorder contraindication to surgery have been ruled out. Documentation of this evaluation must be included in the request for prior authorization.
- The patient must have undergone an appropriate medical work up which may include upper gastrointestinal series, endoscopy, appropriate preoperative laboratory studies and EKG. A complete physical examination by the attending surgeon and an assessment of thyroid levels is required. If co-morbid conditions (i.e. diabetes or cardiovascular disease) are present, an appropriate evaluation of those conditions is required to ensure that patient is capable of undergoing the procedure.

1. Gastric Restrictive Procedures

Open gastric bypass using a Roux-en-Y anastomosis with an alimentary or "Roux" limb of 150 cm or less, or vertical-banded gastroplasty, may be considered **medically necessary** in the treatment of morbid obesity (*see General Criteria for Patient Selection and Coverage*) that has not responded to conservative measures. Further, bariatric surgery should be performed in appropriately selected patients, by surgeons who are adequately trained and experienced in the specific techniques used, and in institutions that support a comprehensive bariatric surgery program, including long-term monitoring and follow-up post-surgery.

Laparoscopic gastric bypass using a Roux-en-Y anastomosis is considered **medically necessary** in the treatment of morbid obesity that has not responded to conservative measures. Further, bariatric surgery should be performed in appropriately selected patients, by surgeons who are adequately trained and experienced in the specific techniques used, and in institutions that support a comprehensive bariatric surgery program, including long-term monitoring and follow-up post-surgery.

Adjustable gastric banding, consisting of an adjustable external band placed around the stomach, is considered **medically necessary** in the treatment of morbid obesity that has not responded to conservative measures. Further, bariatric surgery should be performed in appropriately selected patients, by surgeons who are adequately trained and experienced in the specific techniques used, and in institutions that support a comprehensive bariatric surgery program, including long-term monitoring and follow-up post-surgery.

Sleeve gastrectomy is considered **medically necessary** in the treatment of morbid obesity that has not responded to conservative measures.

Gastric bypass using a Billroth II type of anastomosis, popularized as the mini-gastric bypass, is considered **investigational** as a treatment of morbid obesity.

2. Malabsorptive Procedures

Open or laparoscopic biliopancreatic bypass (i.e., the Scopinaro procedure) with duodenal switch may be considered **medically necessary** for treatment of morbidly obese patients with BMI of 50 kg/m² or greater that has not responded to conservative measures.

Biliopancreatic bypass without duodenal switch is considered **investigational** as a treatment of morbid obesity.

Long-limb gastric bypass procedure (i.e., >150 cm) is considered **investigational** as a treatment of morbid obesity.

3. Endoluminal (Endoscopic) Procedures

Endoscopic procedures (e.g., insertion of the StomaphyX™ device) as a primary bariatric procedure or as a revision procedure, i.e., to treat weight gain after bariatric surgery to remedy large gastric stoma or large gastric pouches, are considered **investigational**.

4. Bariatric Surgery in Treatment of Type 2 Diabetes Mellitus

Bariatric surgery is considered **investigational** as a cure for type 2 diabetes mellitus.

5. Revision Bariatric Surgery

Revision surgery to address perioperative or late complications of a bariatric procedure is considered **medically necessary**. These include, but are not limited to, staple-line failure, obstruction, stricture, and non-absorption resulting in hypoglycemia or malnutrition, weight loss of 20% or more below ideal body weight.

Revision of a primary bariatric procedure that has failed due to dilation of the gastric pouch (documented by upper gastrointestinal examination or endoscopy) is considered **medically necessary** if the initial procedure was successful in inducing weight loss prior to pouch dilation and the patient has been compliant with a prescribed nutrition and exercise program and the patient still meets criteria (BMI) for bariatric surgery.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

For New England Health Plan (NEHP) members an approved referral authorization is required.

Benefits for Federal Employee Program (FEP) members may vary. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure.

Patient Selection Criteria

Eligible Providers

Surgeons (MD or DO)

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Related Policies

Gastric Electrical Stimulation

Policy Implementation/Update information

07/31/96	Add to Surgery section	New policy
08/18/00	Replace policy	Policy updated to include expanded discussion of biliopancreatic bypass and gastric banding. Policy statement unchanged
05/31/01	Replace policy	Policy revised to include mini-gastric bypass
02/15/02	Replace policy	Policy revised to include further information on laparoscopic banding. Policy statement unchanged
07/17/03	Replace policy	Policy revised to include the conclusions of the 2003 TEC Assessment. Policy statement added stating laparoscopic gastric bypass is investigational
11/9/04	Replace policy	Policy revised to include revised CPT code 43846; no other aspects of policy reviewed at this time. Coding updated in code table
12/14/05	Replace policy	Policy revised to include the results of the two 2005 TEC Assessments; policy statement regarding laparoscopic gastric bypass changed to medically necessary. Coding updated
07/20/06	Replace policy	Policy updated with sleeve gastrectomy. Sleeve

		gastrectomy is considered investigational
12/12/06	Replace policy	Policy updated with recent TEC Assessment; policy statement changed to indicate that adjustable gastric banding can be considered for those needing bariatric surgery. New references 18 (TEC Assessment) and 41 added. Information added to guidelines section that this policy does not apply to those under the age of 18.
02/14/08	Replace policy	Policy updated with literature review and clinical vetting. Policy statement added that endoscopic procedures for those who regain weight are investigational. Reference numbers 42 to 50 added
9/16/08	Policy Adopted by BCBSVT	Approved by Clinical Advisory Committee
03/12/09	Replace policy.	Policy update with literature review. Reference numbers 51-87 added. Policy statement added which states that this surgery is investigational as a cure for type 2 diabetes mellitus; statement added that biliopancreatic diversion with duodenal switch may be considered medically necessary; Policy Guidelines updated related to indications for surgery in adolescents and to further clarify definition of morbid obesity. Policy re-titled "Bariatric Surgery."
5/14/09	Replace policy/correction only	Policy History for 3/12/09 corrected to say "Policy statement added which states that this surgery is investigational as a cure for type 2 diabetes mellitus."
04/25/13	Replace Policy/updates only	Additional indication for sleeve gastrectomy added. Policy updated in new format. References updated. Audit information section added. BlueCard clarification added. New Code table added. CPT-90791 replaces 90801.

Scientific Background and Reference Resources

The policy was updated with a literature search using MEDLINE through December 2011.

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Approved by BCBSVT Medical Directors

Date Approved

Spencer Borden MD
Chair, Medical Policy Committee

Robert Wheeler MD
Chief Medical Officer

Code Table & Instructions

Code Type	Number	Brief Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
ICD-9	278.01	Morbid obesity	
ICD-10	E66.01	Morbid (severe) obesity due to excess calories	This code not effective until 10/1/2014
CPT	43644	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)	Prior Approval Required
CPT	43645	Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and small intestine reconstruction to limit absorption	Prior Approval Required
CPT	43770	Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (e.g., gastric band and subcutaneous port components)	Prior Approval Required
CPT	43771	Laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only	Prior Approval Required
CPT	43772	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only	Prior Approval Required
CPT	43773	Laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only	Prior Approval Required

CPT	43774	Laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components	Prior Approval Required
CPT	43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (i.e., sleeve gastrectomy)	Prior Approval Required
CPT	43842	Gastric restrictive procedure, without gastric bypass, for morbid obesity; vertical-banded gastroplasty	Prior Approval Required
CPT	43843	Gastric restrictive procedure, without gastric bypass, for morbid obesity; other than vertical-banded gastroplasty	Prior Approval Required
CPT	43845	Gastric restrictive procedure with partial gastrectomy, pylorus-preserving duodenoileostomy and ileoileostomy (50 to 100 cm common channel) to limit absorption (biliopancreatic diversion with duodenal switch)	Prior Approval Required
CPT	43846	Gastric restrictive procedure, with gastric bypass for morbid obesity; with short limb(150 cm or les) Roux-en-Y gastroenterostomy	Prior Approval Required
CPT	43847	Gastric restrictive procedure, with gastric bypass for morbid obesity; with small intestine reconstruction to limit absorption	Prior Approval Required
CPT	43848	Revision, open, of gastric restrictive procedure for morbid obesity, other than adjustable gastric restrictive device (separate procedure)	Prior Approval Required
CPT	43886	Gastric restrictive procedure, open; revision of subcutaneous port component only	Prior Approval Required

CPT	43887	Gastric restrictive procedure, open; removal of subcutaneous port component only	Prior Approval Required
CPT	43888	Gastric restrictive procedure, open; removal and replacement of subcutaneous port component only	Prior Approval Required
CPT	90791	Psychiatric diagnostic evaluation	
HCPCS	S2083	Adjustment of gastric band diameter via subcutaneous port by injection or aspiration of saline.	
Type of Service		Surgery	
Place of Service		Inpatient	